



Montgomery County Department of Health and Human Services  
Licensure and Regulatory Services  
255 Rockville Pike, Ste 100, 1<sup>st</sup> Floor, Rockville, Maryland 20850  
Phone: 240-777-3986 Fax: 240-777-3088  
[www.montgomerycountymd.gov/licensure](http://www.montgomerycountymd.gov/licensure)

**CERTIFIED FOOD SERVICE MANAGER APPLICATION**  
(LICENSES ARE NOT TRANSFERABLE FROM LOCATION TO LOCATION OR PERSON TO PERSON)

☐ New ☐ Renewal ☐ Replacement of Lost Card **TODAY'S DATE:** \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: (WORK) \_\_\_\_\_ Telephone No.: (HOME) \_\_\_\_\_

Email Address (**REQUIRED**): \_\_\_\_\_

Mailing Address (If Different): \_\_\_\_\_

Last 4 Numbers of Social Security Number: \_\_\_\_\_

Name of Organization Issuing Certificate: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Or

Transferring Certified Manager's card from another approved jurisdiction:

Issued By: \_\_\_\_\_ Card Expiration Date: \_\_\_\_\_

I hereby certify that the above information is accurate and complete. In addition, I understand that providing false information may result in revocation of my Montgomery County Certified Food Service Manager's License.

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

**Payment Method**

☐ Check ☐ Money Order ☐ Visa ☐ MasterCard **CASH IS NOT ACCEPTED** Amount: \$ \_\_\_\_\_

Credit card payments fax to: 240-777-4531 (confidential fax line).

Credit Cardholder's Name: \_\_\_\_\_

Credit Card No: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ 3 Digit Security Code: \_\_\_\_\_

**I agree to pay the indicated total amount according to card issuer agreement:**

Cardholder's Signature: \_\_\_\_\_

Submit completed application and application fee to address at the top of the application. Checks or money orders are payable to "Montgomery County, Maryland".

**OFFICE USE ONLY**

Receipt No: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Date Issued: \_\_\_\_\_ ID Number: \_\_\_\_\_

Check No: \_\_\_\_\_ Expires: \_\_\_\_\_ Staff Initials: \_\_\_\_\_